MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 10, 2002
10:18 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Characteristics of long-term care hospitals and workplan -- Sally Kaplan

MR. HACKBARTH: Now we're to our last item for today, characteristics of long-term care hospitals and workplan. This is follow up work that came out of a brief letter report, if I recall, to Congress last year, which raised a number of questions. And the purpose of this work is to try to answer some of those questions, right?

DR. KAPLAN: Correct. First, you asked for more information about long-term care hospitals, our LTCHs as the acronym is. I'll very briefly summarize the most recent research on these facilities.

Second, our letter to CMS commenting on the proposed PPS raised questions about these facilities and I'll provide information about our workplan to answer these questions. I'd like your comments on the workplan and the scope of the proposed research.

As you know, long-term care hospitals provide intensive care to patients with multiple comorbidities for extended periods of time. To be certified as an LTCH, facilities must meet the conditions of participation for hospitals and demonstrate that they have a Medicare average length of stay greater than 25 days.

All post-acute care grew rapidly in the 1990s. However, one reason why policymaker are so interested in long-term care hospitals is because they were the post-acute setting with the most rapid growth. In less than a decade, the number of long-term care hospitals more than doubled and Medicare spending for them more than quadrupled, as you can see on the table on the screen.

The rapid growth in long-term care hospitals within hospitals in the last decade has heightened concern among CMS and other policymakers. Hospitals within hospitals make it easier for host hospitals to move patients out of acute care and into the LTCH without the patient having to leave the building. Because Medicare makes two payments for the patient instead of one DRG payment, this behavior increases Medicare cost.

Analysts generally have considered long-term care hospitals to be a heterogenous group of facilities whose only common feature was a length of stay greater than 25 days. Recent research for CMS by Corbin Liu and his associates, however, found that these facilities can be characterized by their certification date. They separated long-term care hospitals into three cohorts. Old hospitals, certified before October 1983, which was before the inpatient PPS, middle hospitals certified between October 1983 and September 1993, and the decade after the PPS was implemented and new hospitals certified after September, 1993.

When we look at the map on the screen, we can see the rapid growth in long-term care hospitals. Old hospitals are green dots, middle hospitals are purple dots, and new hospitals are red. This didn't come out well in the black and white forum or

media, so that's why we didn't include it in your handout.

Certification cohorts track changes in the long-term care hospital industry. For example, old hospitals generally are large and located in the northeastern United States. They are generally non-profit or government-owned.

The middle cohort tracks the first entry of for-profit long-term care hospitals, generally medium-sized free-standing facilities located primarily in the south. Many of them specialize in respiratory care.

The new cohort, which is the red dots, tracks the rapid growth of small, for-profit long-term care hospitals. Many are hospitals within hospitals. And they are located mainly in the southern United States.

Cohorts are strongly associated with other characteristics, such as location, ownership, hospital affiliation, payer's share of discharges, average length of stay, Medicare median operating cost per case, and bed size.

Liu and associates also found that most long-term care hospitals specialize. Most specialize in respiratory care, rehabilitation care, or a combination of the two. They also found that three hospitals specialize in treating mental diseases and disorders, and that a small number of niche hospitals had unique patient populations. For example, one hospital provides care to a prison population. In your mailing material I've summarized information about the four groups of specialty long-term care hospitals.

The primary goal of the Liu study was to provide insight into the differences among long-term care hospitals and other post-acute care facilities. The findings provide some evidence that long-term care hospitals are different from skilled nursing facilities or SNFs and inpatient rehabilitation facilities.

Long-term care hospitals' patients appear to be different. They are younger, more likely to be disabled, and more often dually eligible. They frequently have diagnoses not commonly found in either SNFs or rehab facilities.

In addition, long-term care hospitals receive different ancillary services and different amounts of ancillaries compared with SNF and rehab patients. For example, 10 percent of long-term care hospital patients received blood in 1997 compared with 3 percent of rehab patients and 2 percent of SNF patients.

However, more work needs to be done to distinguish between long-term care hospital patients receiving rehab services and patients in rehab facilities and between patients in the three long-term care hospitals specializing in mental diseases and patients in inpatient psychiatric care.

We don't know whether acute care hospitals and long-term care hospitals differ. We known that beneficiaries live in areas where there are no long-term care hospitals, as you saw on the map. This takes us to the policy questions we'll be answering with our workplan.

The first question is about what happens to beneficiaries who live in areas where there are no long-term care hospitals. To answer this question we'll identify market areas with and without long-term care hospitals and compare patterns of care for

patients who are clinically similar. Then we'll compare total Medicare payments for Part A services and outcomes.

Another important question has to do with acute care hospitals, differences between those that have and don't have strong relationships with long-term care hospitals. Liu and associates found that hospitals within hospitals, on average, receive 62 percent of their cases from their host hospital. Other acute care hospitals, however, have strong referral relationships with long-term care hospitals and may have similar behavior to host hospitals with onsite long-term care hospitals.

We'll be assessing financial performance for the different groups of acute care hospitals. We'd also like to know what differences exist between free-standing long-term care hospitals and hospitals within hospitals. We'll be comparing financial performance, total Medicare payments, and outcomes for these two groups.

Other questions may require clinical research. For example, we might be able to partly answer questions about rehab and mental disease patients in long-term care hospitals and how they differ from patients in inpatient rehab and inpatient psychiatric facilities respectively. However, these questions may be better answered by clinically oriented research.

I'm happy to answer your questions and hear your comments.

MR. FEEZOR: Were there any, in the Liu study, did they do any correlation between the growth of long-term care or LTCHs and those states that had maybe limitations on their SNF beds in order to keep Medicaid payments down?

DR. KAPLAN: No, they did not. As far as I know, they did not look at the certificate of need states compared to those that don't have certificate of need. I believe we could put that into a multivariate model as an indicator for the hospitals.

MR. FEEZOR: Just take a look at that, just more of a visceral call as I looked at that.

MS. RAPHAEL: I was just curious, you said most of this population is a younger population that's dually eligible. Yet Medicaid pays for about 10 percent of the cost. I wasn't clear as to why Medicaid covers such a low percent of the cost?

DR. KAPLAN: No, Medicaid basically has a heavy proportion of payments in the old hospitals. I don't think anything was ever really said about how much Medicaid covered. Perhaps I'm mistaken, but I don't remember that.

MS. RAPHAEL: [Off microphone.] I thought I read that Medicaid covered 10 percent of the costs, but I might not have read it accurately. But I would be interested in the payer mix.

DR. KAPLAN: And there is a big difference in the age cohorts. For example, in the old hospitals, the old long-term care hospitals, I believe the Medicaid share is about 25 percent. And by the time you get to the new hospitals, it's 4 percent. So you have a big difference and the age cohort is definitely correlated with the share of Medicaid patients, discharges.

DR. NEWHOUSE: Sally, I thought this was a really nice research plan, and I only had one minor comment. At one point in our written materials, you suggest that we may want to recommend to the Congress that they request an Institute Of Medicine

report. The Institute of Medicine generally doesn't do primary data collection and it seems to me it would be better to suggest that AHRQ do it.

DR. REISCHAUER: Will you have information on where private payers send their similarly diagnosed people? Is this something which is largely Medicare and some Medicaid? From what you wrote, which I agree with Joe, really sounds interesting. It sort of looks like this has spring up almost in reaction to the --

DR. NEWHOUSE: But they have a lot of per diem, which would change the picture here.

DR. KAPLAN: To answer your question, we won't be able to compare similar patients because we aren't going to have the information on the private patient's diagnoses and comorbidities, which is what we're going to use to control for clinical similarity. So we won't have that, because we don't have the claims for the private patients. We only have the claims for the Medicare patients.

I think the only thing we could do would indicate whether the share of the Medicaid patients that a hospital had.

DR. REISCHAUER: What I'm interested in is the share of private pay folks that they have.

DR. KAPLAN: I'm not sure whether it's on one of your tables in the mailing material, but the share of private patients is on table one in your mailing materials. If you look at the cohorts, the old hospitals have 26 percent, the middle hospitals have 20 percent, and the new hospitals have 16 percent of their discharges being private pay.

So they're not exclusively Medicare animals, but the newer ones seem to be primarily Medicare animals.

MR. HACKBARTH: Thank you, Sally.